TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
David Huang, MD

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-2737-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Texas Mutual Insurance on 11/22/2014, this request was in response to a $650.00 reduction of the $1150.00 for the Designated Doctor Exam performed on 09/20/2014. Unfortunately our request was denied and we are seeking the balance owed to us…"

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… **DAVID HUANG, MD** performed a Designated Doctor MMI/IR exam for the claimant on 9/20/14. The health care provider billed 99456-W5-WP for the MMI/IR. Texas Mutual staff denied the MMI/IR portion of the exam requesting a valid code &/or modifier be billed. According to documentation (DWC-69 and Designated Doctor report) provided by the health care provider the claimant has not reached MMI (see DWC 60 packet) thus the provider billed using an incorrect 'WP' modifier. Per Rule 134.204 (i) and (j) for Designated Doctor exam when MMI has not been reached modifier 'NM' is to be billed (i.e. 99456-W5-NM). The health care provider has not provided Texas Mutual with a corrected claim.

Given the above no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 20, 2014	Designated Doctor Examination (MMI/IR)	$650.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The insurance carrier denied disputed CPT Code 99456-W5-WP with claim adjustment reason code "CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing," and "732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed." 28 Texas Administrative Code §134.204 (j)(2)(A) states, "If the examining doctor, other than the treating doctor, **determines MMI has not been reached**, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier 'NM' shall be added" [emphasis added]. Further, 28 Texas Administrative Code §134.204 (j)(4)(C)(iii) states, in relevant part, "If the examining doctor performs the MMI examination **and the IR testing of the musculoskeletal body area(s)**, the examining doctor shall bill using the appropriate MMI CPT code with modifier 'WP'" [emphasis added]. Review of the submitted information finds that the requestor performed and MMI examination and found that the injured employee was not at MMI. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	June 4, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.